Vermont Department of Disabilities, Aging and Independent Living

ATTENDANT SERVICES PROGRAM APPLICATION

Please print clearly & firmly

NAME: _____
First Middle Initial Last

MARITAL STATUS: _____ GENDER: Male _____ Female _____
Divorced, Legally Separated, Married, Single, Widowed

DATE OF BIRTH: _____ / _____ / _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____
MM DD YYYY

TELEPHONE: (_____) _____ - _____ MEDICARE: Yes___ No ___ MEDICAID: Yes___ No ___

RESIDENTIAL ADDRESS: _____
Street City/Town State Zip

MAILING ADDRESS:

_____
☐ Check box if same as residential address Street / P.O. Box City/Town State Zip

Office Use Only: Medicaid Code: _____ **Date** _____ **Initials** _____ **Date Application Received** _____
2 digit code MM/DD/YYYY MM/DD/YYYY

1. Describe your primary disability and how it affects your daily activities:

_____
_____
_____

2. Do you need physical assistance with any of these activities? (Check all that apply)

☐ Dressing ☐ Toileting ☐ Bed mobility ☐ Eating
☐ Bathing ☐ Transferring ☐ Positioning ☐ Preparing meals
☐ Grooming ☐ Range of motion ☐ Ambulation/Mobility in home

3. Who helps you with these activities? _____

4. Are you able to hire, train & supervise your own attendant? ☐ Yes ☐ No ☐ Not sure
If you have a guardian or similar representative, include a copy of document; and please explain below:
Guardian's Name: _____ Telephone: _____-_____

APPLICANT STATEMENT

I understand that further information maybe required to determine my eligibility for services. I have read the information on the reverse side of this form, including my rights & responsibilities. I certify that the information on this application is true and accurate to the best of my knowledge.

Applicant's signature: _____ **Date:** _____

Witness to mark if unable to sign name: _____

Guardian's signature if applicable: _____

Person/Agency helping to apply: _____ Telephone: _____-_____

Alternate contact person name: _____ Telephone: _____-_____

Return white & yellow copies to:
Keep pink copy.

Attendant Services Program
Department of Disabilities, Aging and Independent Living
103 South Main Street Weeks Bldg
Waterbury, VT 05671-1601
Telephone (802) 241-2431

ATTENDANT SERVICES PROGRAM

DESCRIPTION

It is the purpose of the Attendant Services Program to foster independence by paying for attendant services to eligible adult Vermonters residing in settings where such services are not otherwise available. It is also the purpose of the Attendant Services Program to enable its participants to exercise as much control as they can over the direction and provision of their attendant services. ASP participants (or agents under Personal Services) must be able and willing to hire, train, schedule and supervise their own attendants**.**

ASP programs and eligibility criteria:

General Fund Personal Services

(1) Have a disability;
(2) Need attendant services for at least one activity of daily living, or meal preparation; and
(3) Be eligible for Medicaid.

General Fund Participant Directed Attendant Services

(1) Have a permanent and severe disability; and
(2) Need attendant services for at least two activities of daily living; and
(3) Be capable of directing his or her attendant care services.

Medicaid Participant Directed Attendant Services

(1) Have a permanent and severe disability; and
(2) Need attendant services for at least two activities of daily living; and
(3) Be capable of directing his or her attendant care services;
(4) Be able and willing to employ attendants other than his/her spouse or civil union partner; and
(5) Be eligible for Medicaid.

Applicants to the general fund programs may be placed on a chronological waiting list depending on eligibility and funding. The ASP Eligibility Committee reviews all assessments and authorizes service awards based on a determination of the applicant's needs and the availability of other services.

RIGHTS AND RESPONSIBILITIES

RELEASE OF INFORMATION

By signing this application you give permission, as you indicate, for the Department to obtain and share any personal and financial information necessary to determine your eligibility for and the amount of services. All information will be respected as confidential and will be used solely to facilitate receiving services. You may revoke your consent at any time by contacting the Department.

OBLIGATIONS & PAYROLL

You must know and agree to comply with the rules and regulations governing the Attendant Services Program. You will be responsible for submitting payroll information required by the State.

APPEAL RIGHTS

If you disagree with a decision of the eligibility committee or the Department, you have the right to request an informal review, a formal review by the Commissioner; or a fair hearing from the Human Services Board.